Testimony of Lori L. Hauser, Ph.D., ABPP
Judiciary Committee Public Hearing re: SB1027
Wednesday, April 1, 2015

Opening: Senator Coleman, Representative Ton, and distinguished members of the Judiciary Committee, I thank you for the opportunity to offer testimony in support of this very important piece of legislation. My name is Dr. Lori Hauser, and I am a psychologist with the State of Connecticut, an 1199 employee with the Whiting Forensic Division of Connecticut Valley Hospital. I am also board certified in Forensic Psychology through the American Board of Professional Psychology. I strongly urge you to vote in favor of SB1027, which clarifies and augments our existing statute regarding the management of individuals under the Psychiatric Security Review Board (PSRB). Chief among these changes is the provision that makes it permissible to impose a bond and to confine to a correctional setting an NGRI acquittee who continues to engage in such acts of violence that they are unable to managed in a hospital setting. I want to clarify a couple of common misconceptions about the concept of insanity, and about the nature of mental illness and its relation to violence.

Insanity: One common misconception about insanity is that it is permanent and unrelenting in nature; that is, 'once NGRI, always NGRI'. Although mental illness is chronic not always fully remitting, insanity is a legal concept that refers to a person's mental state at a specific time period, the time of the crime. In other words, it is a time-sensitive, act-specific concept, whereas mental illnesses fluctuate, resolve, worsen, change in their clinical presentation, and influence an individual's behavior in different ways at different times. Symptoms that influence a person's behavior at the time of a crime typically resolve and do not affect them in the same way at a later point. Indeed, a person could even be found NGRI of one criminal act and guilty of another criminal act during the same time period; so, it is not an all-or-nothing thing. Furthermore, just because an acquittee is confined to a hospital does not mean that they are floridly psychotic, or that they are incapable of rational thought or of planful, deliberate behavior, or that they are even symptomatic at all. It just means that they still pose a risk to society if released. And, just because someone has been diagnosed with a mental illness does not mean that their violence stems from that mental illness, or, as I said, that the symptoms of that illness even exist any longer. Some violence is the direct result of a person's illness, and some violence is the product of a more enduring, pervasive personality pattern that is immune to treatment.

According to the PSRB statute, we are required to report to the Board *every six months* regarding an acquittee's progress, and we must defend their continued confinement *every six months* based on the existence of ongoing psychiatric disabilities that make them dangerous to self or others if released. If 'once NGRI, always NGRI', there would be no point in conducting such assessments. Numerous court decisions (such as *Foucha v. Louisiana*) point to the fact that there must be *continuing evidence* of mental illness *and* dangerousness in order to continue to confine someone. All of this implies that the contribution of a mental illness to a person's behavior in general and violence specifically waxes and wanes over time. Just because someone lacked the requisite mental state at some past point in time does not mean that they do not currently have the capacity to understand right from wrong and to conform their behavior to that which is right. And with the *capacity* to do so, any *failure* to do so should leave them open to the same procedural mechanisms put in place to protect society's citizens from their ongoing violence.

Violence: Another point I would like to make is about the nature of violence and its underpinnings. Our staff accept that they will be exposed to and will have to manage violent patients, and they do an incredible job at preventing such behavior or at managing it when it does arise. There are, however, outliers who simply are too dangerous to manage in this setting, not because of any psychosis or impulse control problems or other serious mental illness. There is violence that stems from a person's mental illness, such as the individual who becomes paranoid that others are harming (or are going to harm) them and lashes out in an effort to protect themselves. That kind of violence is understood, expected, and treatable in this setting. However, there is also the violence, intimidation, and manipulation of the less fortunate and more vulnerable that stems from an enduring, pervasive personality and pattern of behavior that repeatedly disregards the rights and securities of others without care or remorse. Our patients are at risk for being abused and manipulated by such individuals, and there is no treatment for that kind of violence, only management. Therapy is even contraindicated for such individuals (assuming they are even willing to accept it) because it makes them better at what they do (that is, manipulating, intimidating, and taking advantage of others).

Maximum security: Another misconception I would like to clarify has to do with the nature of maximum security environments. We are not all one in the same. Whiting Forensic and the Department of Correction are both maximum security environments, but we have very different missions – treatment vs. punishment – and very different policies regarding the behavioral management of the individuals in our care. In short, the Department of Correction can use tools, techniques, and strategies that we are not permitted to use. They are able to keep inmates sequestered from other inmates *and yet still provide some sort of treatment to them*. In our setting, we can only isolate or restrain an individual when they are believed to be an imminent risk of harming themselves or others. As such, it is next to impossible for anyone to receive treatment when one person's violence cannot be managed. Other patients hide in their rooms or refuse to speak up in group (for fear that their past behaviors or current opinions will get them assaulted). Incalculable resources are consumed trying to manage one individual that little time and resources are available for others. Even the *violent person's* right to treatment is compromised. I have even discussed with high level administrators in the Department of Correction and we concur on this matter: In the Department of Correction, an inmate can be isolated from others while still receiving services. In our environment, we cannot sequester patients away from others (without it being classified as a 'seclusion or restraint', which hinges on imminent risk). By providing open opportunities for repeated acts of violence, we are doing no more than enabling the behavior and ever increasing the negative consequences (typically, further confinement, whether here or there) they receive.

Staff: Finally, I just want to end by saying one thing: Our staff at Whiting are incredible people who do an incredible job. They put themselves at risk every day to protect others: to protect each other, to protect us, to protect the patients. To protect both the victims of violence as well as those who perpetrate the violence. They are the ones who run toward the violence, not away. They try to make sure everyone goes home safely, and that those must vulnerable individuals who are placed in our care, are safe and secure and can get the treatment they need to aid in their recovery. Everyone in this room knows that no right is absolute; ensuring that individuals' rights are upheld requires a balancing of interests. And, with respect to the bill before you, we believe

that it is not acceptable for all but one individual's rights to be violated so that that one individual's rights may be upheld.

I want to emphasize that this bill is not about dumping our most vulnerable citizens, our mentally ill, into prison. It is not about nullifying their NGRI acquittal because we have some retributive need to punish them. It is not about washing our hands of problematic individuals simply because they commit one isolated act of violence. We're talking about outliers here, those who demonstrate, either over a period of time or with such a significant act of brutality, that they cannot be managed in this setting. What we urge you, our legislators, to consider today is that this is an issue of balancing individuals' rights: that is, one patient's right to treatment versus every other patient's right to treatment, and all patients' and staff's right to be free from undue violence where they live and work. There must be provisions in place to ensure that we can promise this to all those affected. For these reasons, I and my colleagues across all disciplines strongly urge you to vote in favor of SB1027.